TEXAS BOARD OF HEALTH
APPLICATION FOR ADVISORY COMMITTEE APPOINTMENT

Name of Committee/Board FAMILY PLANNING ADVISORY COMMITTEE

Initial Appointment **9** Reappointment **9**

Position Applied for _____

(Choose from the list of positions in the Board of Health rules relating to this committee/board)

Please complete this application in a brief, yet informative manner. If questions are not applicable, enter "NA." Your eligibility will be determined from the information you submit on this application and your letters of reference. No resumes will be considered.

1. Name: _____

First *Middle* *Last*

2. Race/Ethnicity:
   _____ White
   _____ Black
   _____ Hispanic
   _____ American Indian/Alaskan
   _____ Asian/Pacific Islander
   _____ Other: _____

3. Gender:
   _____ Male
   _____ Female

4. Education: _____

5. Professional License, Registration or Certification, if applicable: _____

6. Relevant Experience (paid employment or volunteer): _____

7. Why do you wish to serve in this capacity? _____

8. Personal and professional achievements (include activities which address contributions you could make to the committee or board):

9. Have you ever been disciplined by any licensing board/professional or civic organization? _____Yes _____No

If yes, please explain _____

10. Have you ever been convicted of a felony or a misdemeanor (excluding traffic violations)? _____Yes _____No

If yes, please explain _____

11. Home Address

Street or P.O. Box *Apartment #*

City *State* *Zip*

Area Code/Home Telephone *Facsimile Number*

Electronic Mail Address

13. Please indicate where you would like to receive future communications:

_____ Home _____ Employment

12. Employment Address

Name of Employer

Street or P.O. Box *Suite #*

City *State* *Zip*

Area Code/Business Telephone *Facsimile Number*

Electronic Mail Address

Current Position Title

14. PLEASE ATTACH ONE (MINIMUM) OR TWO (MAXIMUM) LETTERS OF RECOMMENDATION FROM PROFESSIONAL AND/OR CIVIC ORGANIZATIONS.

I ATTEST THAT ALL INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT.

Signature of Nominee Date

PLEASE RETURN THIS FORM TO:

Shannon N. Walton, MSSW
Family Planning Program
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756